ROBERT A. FRIEDSTAT, DDS, PC

ROBERT A. FRIEDSTAT, DDS, PC **PETER LIAROS, DDS**

Patient Name:
Ms. Mrs. Mr. Dr. _____ Birth Date: _____
(Last) (First)

❑ Married ❑ Single ❑ Child ❑ Other _____

Social Security #: _____

Phone (Home): _____ (Work): _____

Address: _____
Street

_____
City State Zip Code

Have you ever had any of the following? Please check those that apply:

- ❑ Artificial Joint (Hip, Knee, Shoulder)
- ❑ Cancer
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Aids/HIV
- ❑ Glaucoma
- ❑ Drug Dependency
- ❑ Heart Disease
- ☐ Heart Murmur
- ❑ Heart Valves Replacement
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker
- ❑ Radiation Treatment
- ❑ Rheumatic Fever
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Tuberculosis
- O Ulcers

Are you pregnant? ❑ No ☐ Yes Due Date: _____

Are you allergic to any of the following?

- ❑ Aspirin
- ☐ Aceteminophen (Tylenol)
- ☐ Sulfa Drugs
- ☐ Penicillin
- ☐ Jewelry
- ❑ Erythromycin
- ❑ Tetracycline
- ❑ Latex
- ☐ Other _____

- Have you ever had any complications following dental treatment? ❑ Yes ☐ No
  If yes, please explain: _____
- Have you ever taken any of the following medications? Pondimin Redux Fen-Phen ❑ Yes ☐ No
- Are you now under the care of a physician? ❑ Yes ❑ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Are you taking any medications? ❑ No OYes Please List: _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

_____ Date: _____
Signature of patient, parent or guardian

Whom may we thank for referring you to our practice? _____

Employment Information

Your Place of employment: _____

Address _____

Your Occupation: _____

Dental Insurance Information

If you have dental insurance, please give your insurance card and/or form to the receptionist.

This procedure is not covered by medicare or health insurance that is other than dental.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print) _____ have received a copy of this office's Notice of Privacy Practices.

_____

Signature Date

Consent for Services

Patients understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will submit the patient's insurance forms and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I also understand that I am responsible for all fees for services rendered. In the event that Drs. Friedstat and Liaros seek enforcement of the agreement through the services of a collection agency, I shall be responsible for any incidental expenses including all collection costs and reasonable attorney fees.

I have read the above conditions of treatment and agree to their content.

_____ **Date:** _____ **Relationship to Patient:** _____

Signature of patient, parent or guardian